T

Patient Name *Wesley Budd* Number ** 8-6-1910* Page ___

ROCOM
Progress Notes

Date / Problems (No. and Description)	FINDINGS (Subjective and Objective)	PLANS
9-11-78	1st & 2nd degree	
	Burns of both	124 E. 4th So.
	legs from mid-upper	Heber, Ut. 84032
	thigh to toes	
	all around legs & thighs	
	Dressed c̄ Silvadene	Retired
	4 4 Curlex & many	
	3x3 sponges —	
	Rx: Demerol 50 for pain	
	Dalmane for sleep —	
9-19-78	Dressings off legs —	
12-5-78	Croup 4 wks — Rx: Keflex + Terpin H c̄ C	
	See allergy for Med. alg. —	
5/16/80	Ca Prostate 1 yr ago + Radia —	
	Lifting injury to back	
	H.A. — neg	
	Consults Lo back —	

(OVER)

Date / Problems (No. and Description)	FINDINGS (Subjective and Objective)	PLANS

MEDICARE SIGNATURE AUTHORIZATION

MEDICARE PROVIDER: Please complete numbered spaces to include provider number. Period indicated cannot exceed the current year unless signed in the last quarter of a calendar year, in which case cannot exceed the close of the following calendar year.

2 BUDD 15 16 WESLEY 26 27 28 — 29 578-18-9047 A 40

(Last Name) (First Name) (M.I.) (Health Insurance Claim Number)

I request that payment under the medical insurance program be made either

to me or to L. L. Green, M.D., 42 2348 45

(Physician or Supplier Name) (Number)

on any bills for services furnished me by this Physician or Supplier during

the period 49 01 01 79 54 to 55 12 31 79 60

(month day yr) (month day yr)

Wesley M Budd

(Beneficiary Signature)

61 01 15 79 66

(month day year)
(Date Signed)

Distribution: Original: Attach to Medicare Claim Form
Copy: Retained by provider

Form No. MB 405 (5-77)

MEDICARE SIGNATURE AUTHORIZATION

MEDICARE PROVIDER: Please complete numbered spaces to include provider number. Period indicated cannot exceed the current year unless signed in the last quarter of a calendar year, in which case cannot exceed the close of the following calendar year.

2 ____ 15 16 ____ 26 27 28 ____ 29 ____ 40

(Last Name) (First Name) (M.I.) (Health Insurance Claim Number)

I request that payment under the medical insurance program be made either

to me or to _____, 42 ____ 45

(Physician or Supplier Name) (Number)

on any bills for services furnished me by this Physician or Supplier during

the period 49 ____ 54 to 55 ____ 60

(month day yr) (month day yr)

_____ 61 ____ 66

(Beneficiary Signature) (month day year)
(Date Signed)

Distribution: Original: Attach to Medicare Claim Form
Copy: Retained by provider

Form No. MB 405 (5-77)

REQUEST FOR MEDICARE PAYMENT

Form Approved
OMB No.
72-R0730

MEDICAL INSURANCE BENEFITS—SOCIAL SECURITY ACT (See Instructions on Back—Type or Print Information)

NOTICE—Anyone who misrepresents or falsifies essential information requested by this form may upon conviction be subject to fine and imprisonment under Federal Law.

PART I—PATIENT TO FILL IN ITEMS 1 THROUGH 6 ONLY

When completed, send this form to:
Blue Shield of Utah
P.O. Box 270
2455 Parley's Way
Salt Lake City, Utah 84110

Copy from YOUR OWN HEALTH INSURANCE CARD (See example on back)

1 Name of patient (First name, Middle initial, Last name)
Wesley BUDD

2 Health insurance claim number (Include all letters)
578180047LA

☒ Male ☐ Female

3 Patient's mailing address — City, State, ZIP code
124 East 4th South Heber City, Utah 84032

Telephone Number

4 Describe the illness or injury for which you received treatment (Always fill in this item if your doctor does not complete Part II below)
1: first and second degree sunburn, legs
2: croup, URI

Was your illness or injury connected with your employment?
☐ Yes ☒ No

5 If you have other health insurance or if your State medical assistance agency will pay part of your medical expenses and you want information about this claim released to the insurance company or State agency upon its request, give the following information.

Insuring organization or State agency name and address

Policy or Medical Assistance Number

6 I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment below.

SIGN HERE — Signature of patient (See instructions on reverse where patient is unable to sign)
Signature on file. Original attached

Date signed
1-15-79

PART II—PHYSICIAN OR SUPPLIER TO FILL IN 7 THROUGH 14

7 A. Date of each service	B. Place of service (*See Codes below)	C. Code surgical or medical procedures and other services or supplies furnished for each date given	Code	D. Nature of illness or injury requiring services or supplies	E. Charges (If related to unusual circumstances explain in 7C)	Leave Blank
9-11-78	0	Office Call & Treatment	90060	1st & 2nd degree sunburn	$ 15.00	
12-5-78	0	Office Call	90050	Croup, URI	10.00	

8 Name and address of physician or supplier (Number and street, city, State, ZIP code)

Telephone No. 25.00

Physician or supplier code 2348

9 Total charges $ 25.00

10 Amount paid $ 25.00

11 Any unpaid balance due $ -0-

12 Assignment of patient's bill
☐ I accept assignment (See reverse) ☒ do not accept assignment.

13 Show name and address of facility where services were performed (If other than home or office visits)

14 Signature of physician or supplier (A physician's signature certifies that physician's services were personally rendered by him or under his personal direction)
A. Allen Rd

Date signed
1-15-79

*O—Doctor's Office
IL—Independent Laboratory
H—Patient's Home (If portable X-ray services, identify the supplier)
IH—Inpatient Hospital
ECF—Extended Care Facility
OH—Outpatient Hospital
OL—Other Locations
NH—Nursing Home

FORM SSA-1490D(2) (8-72)

Department of Health, Education, and Welfare
Social Security Administration

HOW TO FILL OUT YOUR MEDICARE FORM

There are two ways that Medicare can help pay your doctor bills

One way is for Medicare to pay your doctor.—If you and your doctor agree, Medicare will pay him directly. This is the assignment method. You do not submit any claim; the doctor does. All you do is fill out Part I of this form and leave it with your doctor. Under this method the doctor agrees to accept the charge determination of the Medicare carrier as the full charge; you are responsible for the deductible and coinsurance. Please read Your Medicare Handbook to help you understand about the deductible and coinsurance. (Because Medicare has special payment arrangements with group practice prepayment plans these plans handle all claims for covered services they furnish to their members.)

The other way is for Medicare to pay you.—Medicare can also pay you directly—before or after you have paid your doctor. If you submit the claim yourself, fill out Part I and ask your doctor to fill out Part II. If you have an itemized bill from him, you may submit it rather than have him complete Part II. (This form, with Part I completed by you, may be used to send in several itemized bills from different doctors and suppliers.) Bills should show who furnished the services, the patient's name and number, dates of services, where the services were furnished, a description of the services, and charges for each separate service. It is helpful if the diagnosis is also shown. Then mail itemized bills and this form to the address shown in the upper left-hand corner. If no address is shown there, use the address listed in Your Medicare Handbook—or get advice from any social security office.

SOME THINGS TO NOTE IN FILLING OUT PART I
(Your doctor will fill out Part II.)

1 & **2** Copy the name and number and indicate your sex exactly as shown on your health insurance card. Include the letters at the end of the number.

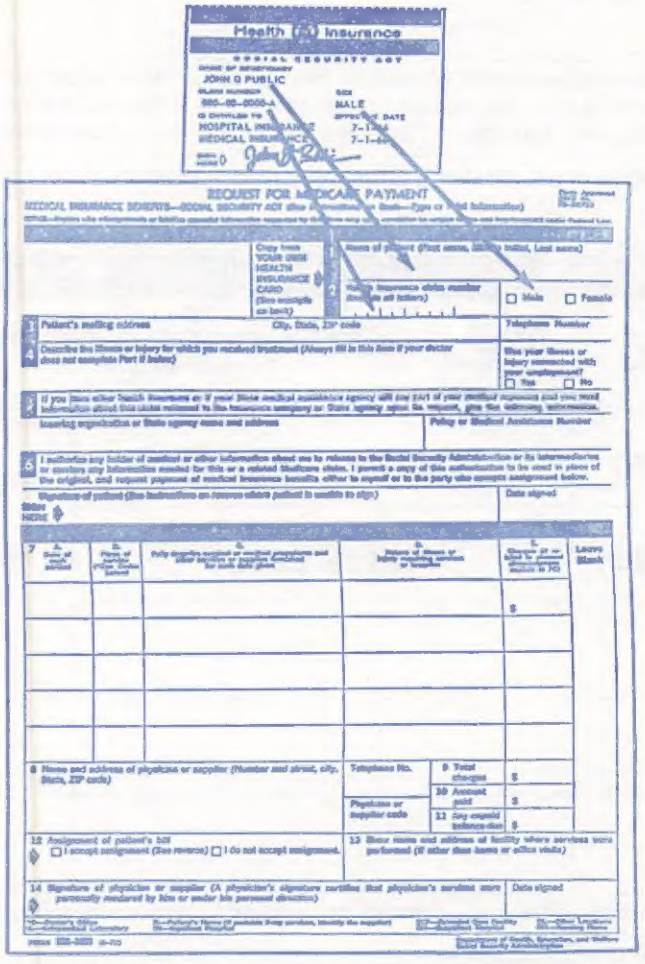
3 Enter your mailing address and telephone number, if any.

4 Describe your illness or injury. Be sure to check one of the two boxes.

5 If you have other health insurance or expect a welfare agency to pay part of the expenses, complete item 5.

6 Be sure to sign your name. If you cannot write your name, sign by mark (X), and have a witness sign his name and enter his address on this line.

If the claim is filed for the patient by another person he should enter the patient's name and write "By," sign his own name and address in this space, show his relationship to the patient, and why the patient cannot sign. (If the patient has died, the survivor should contact any social security office for information on what to do.)



IMPORTANT NOTES FOR PHYSICIANS AND SUPPLIERS

Item 12: In assigned cases the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the carrier if this is less than the charge submitted.

This form may also be used by a supplier, or by the patient to claim reimbursement for charges by a supplier for services such as the use of an ambulance or medical appliances.

If the physician or supplier does not want Part II information released to the organization named in item 5, he should write "No further release" in item 7C following the description of services.

MEDICARE SIGNATURE AUTHORIZATION

MEDICARE PROVIDER: Please complete numbered spaces to include provider number. Period indicated cannot exceed the current year unless signed in the last quarter of a calendar year, in which case cannot exceed the close of the following calendar year.

2 ____ 15 16 ____ 26 27 28 ____ 29 ____ 40

(Last Name) (First Name) (M.I.) (Health Insurance Claim Number)

I request that payment under the medical insurance program be made either

to me or to _____, 42 ____ 45

(Physician or Supplier Name) (Number)

on any bills for services furnished me by this Physician or Supplier during

the period 49 ____ 54 to 55 ____ 60

(month day yr) (month day yr)

_____ 61 ____ 66

(Beneficiary Signature) (month day year)
(Date Signed)

Distribution: Original: Attach to Medicare Claim Form
Copy: Retained by provider

Form No. MB 405 (5-77)

REQUEST FOR MEDICARE PAYMENT

MEDICAL INSURANCE BENEFITS—SOCIAL SECURITY ACT (See Instructions on Back — **Type or Print Information**)

Form Approved OMB No 066-R-0012

No Part B Medicare benefits may be paid unless this form is received as required by existing law and regulations (20 CFR 422.510)

NOTICE—Anyone who misrepresents or falsifies essential information requested by this form may upon conviction be subject to fine and imprisonment under Federal Law.

PART I—PATIENT TO FILL IN ITEMS 1 THROUGH 6 ONLY

When completed, send this form to:
Blue Shield of Utah
P.O. Box 30269
2455 Parley's Way
Salt Lake City, Utah 84125

Copy from YOUR OWN HEALTH INSURANCE CARD *(See example on back)*

1 Name of patient (First name, Middle initial, Last name): Wesley BUDD

2 Health insurance claim number *(Include all letters)*: 578 18 0047 A

☒ Male ☐ Female

3 Patient's complete mailing address (including Apt. no.) City, State, ZIP Code: 124 East 4th South Heber City, Utah 84032

Telephone Number:

4 Describe the illness or injury for which you received treatment *(Always fill in this item if your doctor does not complete Part II below)*: Flu like S/S

Was your illness or injury connected with your employment? ☐ Yes ☒ No

5 If any of your medical expenses will be or could be paid by another insurance organization or government agency, show below

Name and address of organization or agency:

Policy or Identification Number:

Note: If you **Do Not** want information about this Medicare claim released to the above upon its request, check (X) the following block ☐

6 I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment below.

SIGN HERE — Signature of patient *(See instructions on reverse where patient is unable to sign)*: Signature on file. Original attached.

Date signed: 5-16-80

PART II—PHYSICIAN OR SUPPLIER TO FILL IN 7 THROUGH 14

7 A. Date of each service	B. Place of service (*See Codes below)	C. Fully describe surgical or medical procedures and other services or supplies furnished for each date given (if lab service, indicate if automated)	Procedure Code	D. Nature of illness or injury requiring services or supplies	E. Charges (if related to unusual circumstances explain in 7C)	Leave Blank
5-16-80	0	Office Call	90050 B	Eval Flu like S/S	$ 10.00	

8 Name and address of physician or supplier *(Number and street, city, State, ZIP code)*

Telephone No. 654-1822

Physician or supplier code: 2348

9 Total charges: $ 10.00

10 Amount paid: $ -0-

11 Any unpaid balance due: $ 10.00

12 Assignment of patient's bill

☐ I accept assignment *(See reverse)* ☒ do not accept assignment.

13 Name and address of person or facility where services were furnished *(Complete if outside your own office or patient's residence)*.

14 Signature of physician or supplier (I certify that the statements under Physicians' Notes on the reverse apply to this bill and are made a part hereof.)

Date Signed: 7-7-80

O—Doctor's Office H—Patient's Home *(If portable X-ray services, identify the supplier)* SNF—Skilled Nursing Facility OL—Other Locations
IL—Independent Laboratory IH—Inpatient Hospital OH—Outpatient Hospital NH—Nursing Home